ALASKA – 2001 Nursing Facility Transitions State Grant

Identified Problems with the States' Long-Term Care System

- Lack of affordable, accessible housing, assisted living units, independent living units, accessible apartments, and private homes.
- Lack of HCBS resources in rural areas.
- Funding sources for home modifications (Medicaid waivers and state- and local-funded programs) have limits and exclusions that prevent some types of desired home modifications.
- Shortage of direct care providers (personal care attendants, chore/respite workers, and certified nurse assistants).
- Lack of transportation resources. It takes time for people on Medicaid waivers to become eligible for waiver-funded transportation. Some rural communities have no road systems.
- Lack of a unified information and referral system.
- There is no system outside of the discharge planners at hospital facilities for the identification of individuals wanting transition.

Perceived Strengths

- The current Medicaid program utilizes a combination of nursing home authorizations and Medicaid waiver programs to develop balanced long-term care options.
- The partnership among Independent Living Centers and groups such as the Alaskan Commission on Aging.
- The consumer-directed independent living center located on the Kenai Peninsula and the Alzheimer's Resource Center are able to develop, monitor, and distribute funds for services and supports not covered by Medicaid.

Primary Focus of Grant Activities

- Identify and develop partnerships to facilitate nursing facility transition.
- Monitor consumer's situation post-transition to determine if needs are met.
- Provide education and outreach about project to consumers and family members.
- Arrange for additional resources and supports.
- Develop enduring system to transition and divert people from nursing facilities to community and identify entities to secure non-Medicaid funded resources once grant funds end.
- Develop a variety of strategies to increase availability of accessible, affordable housing.

Goals, Objectives, and Activities

Overall Goal. To address the deficiencies in housing, direct service providers, transportation, and resource information in order to enable successful transitions from nursing facilities or diversion from inpatient or rehabilitation hospitals.

Goal. Provide services to transition people from nursing facilities to the community.

Objectives/Activities

- The Project Coordinator will work with nursing facility staff to develop strong working relationships and to better define the needs for successful transition outcomes.
- The Project Coordinator and Care Coordinator will be responsible for extending information to residents' families via pamphlets, newsletters, and conferences.
- Work with the nursing facility staff to identify targeted individuals by reviewing data such as records and assessments.
- Assess each targeted individual's needs for transition to the community based on current assessments and care plans.
- The Project Coordinator will convene a care plan counseling team (consumer and their family with professionals such as a Care Coordinator, NH/Hospital Social Worker etc.) to present a plan for transition and to monitor each individual's situation to determine if his or her needs are met and arrange resources and supports as needed.

Goal. Provide services to divert hospitalized persons from nursing facilities.

Objectives/Activities

- Build relationships with the hospital staff and secure their commitment to participate in the diversion project. The Project Coordinator will become involved with discharge planning, attend staff meetings, maintain regular contacts with the hospital staff, and distribute information.
- Provide general education, information, and outreach (booklets, pamphlets and web information, as well as individual peer counseling to the patients) about the Nursing Facility Transition Project to consumers and family members.
- Work with the hospital staff to identify targeted individuals and assess needs.
- The Project Coordinator will convene a care plan counseling team (consumer and their family with professionals such as a Care Coordinator, NH/Hospital Social Worker etc.) to present a plan for transition and to monitor each individual's situation to determine if his or her needs are met and arrange resources and supports as needed.
- Implement a benchmark study to quantify the number of potential transitions, the number of successful transitions, the number of re-institutionalized patients, and the percentage of clients satisfied with their diversion.

Goal. Develop an enduring system to transition and divert people from nursing facilities to the community to the extent they desire.

Objectives/Activities

- Work in conjunction with Alaska Housing Finance Corporation (AHFC) and other housing resources to increase the availability of accessible, affordable housing.
- Work in conjunction with other initiatives and activities (such as the DSS care plan coordinators, the consumer task force, the Community PASS grant project coordinator, the transportation task force, and the Kenai ILC) to increase the availability of services and supports that will support transitions and diversion.
- Develop a new multi-level universal worker paraprofessional position that can meld separate job functions such as personal care attendant, a chore/respite worker, and a certified nurse assistant.
- Identify entities or programs to secure non-Medicaid resources once grant funds end.
- Evaluate project activities/outcomes and develop recommendations to further improve the transition/diversion program.

Key Activities and Products

- Increase the availability of housing and develop housing options through collaboration with AHFC to advocate for additional Section 8 vouchers.
- Increase the availability of supports and services through collaboration with other providers and care coordinators.
- Work with both nursing and hospital facilities to identify candidates for transition/diversion by building interdisciplinary evaluation teams.
- Develop a new multi-level universal worker paraprofessional position that can meld separate job functions such as personal care attendant, a chore/respite worker, and a certified nurse assistant.
- Implement a benchmark study to quantify the number of potential transitions, the number of successful transitions, the number of reinstitutionalized patients, and the percentage of clients satisfied with their diversion.

Consumer Partners and Consumer Involvement in Planning Activities

Consumer Task Force—consists of individuals with disabilities and/or family members plus state and private agency representatives who actively participate in the state's long-term care plan.

Consumer Partners and Consumer Involvement in Implementation Activities

Consumer Task Force—at each level of analysis, planning, implementation, monitoring, and evaluation activities, task force members have an active role. The task force will continue to meet on a quarterly basis to ensure that project activities support the design and implementation of effective and enduring improvements in community long-term care support systems.

Public Partners

- Governor's Council on Disabilities and Special Education.
- Alaska Commission on Aging (ACoA).
- Human Services Transportation Task Force.
- Division of Medical Assistance (DMA).
- Division of Senior Services (DSS).
- Division of Mental Health and Developmental Disabilities (DMHDD).
- Alaska Mental Health Trust Authority (AMHTA).
- Alaska Housing and Finance Corporation (AHFC)
- University of Alaska, Center for Human Development.

Private Partners and Subcontractors

- Alaska Association of Developmental Disabilities.
- Alaska State Hospital and Nursing Home Association.
- Alliance for Direct Service Careers.

Public and Private Partnership Development/Involvement in the Planning Phase

Public Partners

- The Legislative Long-Term Care Task Force was formed to study long-term care issues and make recommendations for improvements. The interdepartmental Long-Term Care Implementation Team was formed to coordinate the various long-term care programs in the Department of Administration and the Department of Health and Social Services.
- The Governor's Council on Disabilities and Special Education has led the State's effort to bring together the Consumer Task Force in response to the CMS systems change initiative. The State's planning/advocacy boards—including the Governor's Council on Disabilities and Special Education, Alaska Commission on Aging, Alaska Mental Health Trust Authority, State Independent Living Council, and the Medical Care Advisory Committee—provided input in the development of the Plan.

Private Partners

Involvement in planning not cited.

Public and Private Partnership Development/Involvement in Implementation

Public Partners

- Alaska Housing Finance Corporation (AHFC) has allotted 8 vouchers statewide to be used for emergency shelter for people served by this project.
- Division of Medical Assistance (DMA)—within the Department of Health & Social Services—will identify ways to speed up the billing processes.
- Division of Senior Services (DSS)—located in the Department of Administration. DSS will employ care coordinators to help transition/divert people from nursing homes and help develop services in rural and remote communities.

- The University of Alaska, Center for Human Development, will perform the study to ascertain the number of possible transitions, the number of successful transitions and diversions and the percentage of consumers satisfied with the outcome of their decision.

Private Partners

The Alliance for Direct Service Careers and Alaska State Hospital and Nursing Home Association (ASHNA) will work with the Project Coordinator to define a new paraprofessional position. The groups will present a multi-level Universal worker concept that can meld the separate job functions of a personal care attendant, a chore/respite worker, and a certified nurse assistant.

Existing Partnerships That Will Be Utilized to Leverage or Support Project Activities

- *Division of Mental Health and Developmental Disabilities* (DMHDD)—the DMHDD will enhance the ability of providers (particularly rural providers) to participate in the waiver program for people with developmental disabilities, determine methods to better serve people with brain injuries statewide, provide training for Care Coordinators and providers on the ICAP assessment process and Level of Care determinations and inform them of their role in the transition process, and develop a comprehensive approach to health and safety quality assurance at assisted living homes.
- *The Alaska Commission on Aging* (ACoA)—comprising 11 members appointed by the Governor—is charged with advocating for state policy, public and private partnerships, and citizen involvement that enables all older Alaskans to age successfully in their own homes and communities. ACoA will determine what is needed statewide to better serve people with Alzheimer's and related diseases and will expand allowable tasks for respite workers.
- *Alaska Mental Health Trust Authority* (AMHTA)—through a rural outreach project will work to expand participants' knowledge of rural issues, barriers, and services and establish a rural service system and funding systems linkages based on the needs and priorities of the GCDSE and ACoA.
- *The Governor's Council on Disabilities and Special Education* (GCDSE)—is Alaska's planning and advocacy council for individuals with developmental disabilities, advisory panel on the education of children with disabilities, the interagency coordinating council for infants and toddlers with disabilities, and the governing board for the Special Education Service Area (SESA). GCDSE will work to increase the recruitment and retention of direct service workers and will help ensure that Alaska's Nursing Facility Transition Project is integrated into existing statewide systems upon termination of federal funding.

Oversight/Advisory Committee

The Consumer Task Force will meet quarterly to ensure that project activities support effective and enduring improvements in community long-term care support systems. The task force also will attend the Transportation Task Force meetings to work in sync with the Municipal and State transportation programs and work with DSS and the Project Coordinator to prepare recommendations for changing existing waivers to include the new services, procedures, and definitions of the universal worker system.

Formative Learning and Evaluation Activities

- Summative evaluations are the documentation and aggregate analysis of project activities and outcomes and will take 3 forms: 1) an annual summary discussing project accomplishments and impact on policies, procedures, and practices, 2) a final comprehensive evaluation report will act as a retrospective look at the extent and types of systems change within the Medicaid HCBS waivers for transition services and support, and 3) a benchmark study to measure the success over time of individuals who participated in transitioning.
- Formative evaluations will be conducted to assess timelines and progress and facilitate continuous improvement in project activities. Questions will include: Were tasks completed within timelines, followed by discussion of problems encountered and how they were solved? What strategies were used to implement project activities and how effective were they? What worked well? Were recommendations for change implemented and to what degree?

Evidence of Enduring Change/Sustainability

- Alaska is currently in the beginning stages of developing and implementing its nursing facility transition and hospital diversion program; care plan counseling has been on the books for four years; transition resources will be used to hire staff whose only responsibilities will be the development, implementation, and evaluation of a system and process for nursing home transition and hospital diversion.
- The Governor's Council on Disabilities and Special Education will work to increase the recruitment and retention of direct service workers and will help ensure that Alaska's Nursing Facility Transition Project is integrated into existing statewide systems upon termination of federal funding. The Project Coordinator will identify entities or programs to secure non-Medicaid funded resources once grant funds end.

Geographic Focus

This is to be a statewide program, although due to the unique geographic and demographic characteristics of the State of Alaska, it is likely that much of the activity will be focused in the Anchorage, Fairbanks, and Juneau communities.